

# **HEALTH CARE NEEDS AND SOCIAL INTEGRATION AMONG PITTSBURGH'S UNINSURED LATINOS**

by

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# HEALTH CARE NEEDS AND SOCIAL INTEGRATION AMONG PITTSBURGH'S UNINSURED LATINOS

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**BACKGROUND:** The Latino population of greater Pittsburgh is considered invisible because it is not concentrated within one geographic area. This is of great public health significance, because such dispersion is a major barrier for Latinos seeking quality health care and social services. In the last ten years, this population has grown over 44%, and many of the estimated 20,000 Latinos in the Pittsburgh area do not have medical insurance. Across the nation, research has shown that Latinos often suffer from higher incidence of diseases and accidental deaths. Latinos also frequently experience limited access to health care and social services, and the level of social integration experienced by population members is directly related to this diverse community's quality of life.

**METHODS:** This study is based on qualitative interviews with a small, purposive sample of young adult Hispanic immigrants, a group likely to experience barriers to accessing services. A free clinic, staffed by bilingual volunteers, was the initial access point to reach uninsured population members. Interviews with participants were recorded, transcribed, and studied to discover which health care and social service needs the community feels they lack, and how their level of social integration was related to their access to services.

**RESULTS:** The most frequently mentioned service needs were dental services, health insurance, bilingual health service providers and/or translation services, and English language classes. Social isolation, lack of legal documentation, fear, racial discrimination, and lack of

cultural competence on behalf of institutional employees were frequently cited as major barriers to accessing services. The length of respondents' stay in Pittsburgh did not appear to have a significant effect on improving respondents' access to needed services. Access to services was related more to the size and extent of one's social network, which usually consisted of family members who had lived in Pittsburgh before the respondent arrived, or which grew slowly over the time the respondent lived in Pittsburgh.

**CONCLUSIONS:** Pittsburgh's Latino population would benefit from increased outreach efforts and increased community mobilization strategies. As a new growth community, Pittsburgh service providers are not fully prepared to reach the needs of the population. Additional research, qualitative in nature, will help to increase awareness and understanding of the challenges faced by this community as it seeks to access much needed services and health care.

## **NECESIDADES MÉDICAS E INTEGRACIÓN SOCIAL ENTRE LOS LATINOS SIN SEGURO MÉDICO EN PITTSBURGH**

**ANTECEDENTES:** La población latina en el área de Pittsburgh está considerada invisible debido a que no está concentrada en un área geográfica. Esta dispersión es una barrera significativa para proveer servicios médicos y sociales de calidad a los latinos. En los últimos diez años, esta población ha crecido más del 44%, y muchos de los 20,000 latinos que se estima residen en el área de Pittsburgh no tienen seguro médico. A nivel nacional, las investigaciones han demostrado que los latinos sufren de una incidencia más alta de enfermedades y de muertes accidentales que la población general. Los latinos también tienen frecuentemente acceso limitado al cuidado médico y a los servicios sociales, y el nivel de integración social de los miembros de la población se relaciona directamente con la calidad de la vida de esta diversa comunidad.

**MÉTODOS:** Este estudio utiliza entrevistas cualitativas con una muestra pequeña, de inmigrantes adultos jóvenes, porque son el grupo que más probablemente tiene barreras para el acceso a los servicios. Los entrevistados fueron elegidos intencionalmente para representar la variedad de los latinos sin seguro. Una clínica gratis, atendida por voluntarios bilingües, fue el punto de acceso inicial para contactar a los miembros de la población sin seguro. Las conversaciones con los participantes fueron grabadas, transcritas, y estudiadas para descubrir las

carencias de esta comunidad en cuanto al cuidado médico y los servicios sociales, y cómo la integración social afecta o mejora su acceso a los servicios.

**RESULTADOS:** Servicios dentales, seguro médico, empleados de salud bilingües y/o intérpretes, y clases de inglés fueron las necesidades más frecuentemente mencionadas. El aislamiento social, la carencia de documentación legal, el miedo, la discriminación racial, y la carencia de competencia cultural entre los empleados de las diversas instituciones fueron citados con frecuencia como barreras importantes para acceder a los servicios. El tiempo que los participantes han permanecido en Pittsburgh no parece tener mucho efecto en mejorar el acceso a los servicios necesarios. Los resultados sugieren que el acceso está relacionado más con el tamaño y la intensidad de su red social, que está compuesta por los miembros de la familia que residían en Pittsburgh desde antes de de la inmigración del participante, o que creció lentamente durante el tiempo que el participante ha vivido en Pittsburgh.

**CONCLUSIONES:** La población latina de Pittsburgh se beneficiaría de esfuerzos para llegar más a la población (“outreach”) y de estrategias crecientes para la movilización de la comunidad. Como en otras poblaciones de "nuevo crecimiento" latino, los proveedores de servicios en Pittsburgh no están adecuadamente preparados para satisfacer las necesidades de la población. Investigaciones adicionales, con métodos cualitativos, ayudarán a aumentar el conocimiento y entender los retos que enfrenta esta comunidad.

## TABLE OF CONTENTS

<b>FOREWORD.....</b>	<b>XII</b>
<b>1.0 INTRODUCTION.....</b>	<b>1</b>
<b>1.1 DEFINITIONS.....</b>	<b>3</b>
<b>2.0 OBJECTIVES .....</b>	<b>4</b>
<b>3.0 BACKGROUND .....</b>	<b>5</b>
<b>3.1 HEALTH STATUS .....</b>	<b>5</b>
<b>3.2 ACCESS TO HEALTH CARE .....</b>	<b>8</b>
<b>3.2.1 Perspectives on barriers to accessing health care .....</b>	<b>9</b>
<b>3.2.2 Health insurance .....</b>	<b>12</b>
<b>3.2.3 Immigration status .....</b>	<b>13</b>
<b>3.2.4 Discrimination and prejudice .....</b>	<b>13</b>
<b>3.2.5 Cultural orientation to health care.....</b>	<b>14</b>
<b>3.2.6 Acculturation, assimilation, and language.....</b>	<b>16</b>
<b>3.3 A LEGACY OF LIMITED OPPORTUNITY .....</b>	<b>19</b>
<b>3.4 COMMUNITY INTEGRATION AND SOCIAL SUPPORT NETWORKS.....</b>	<b>21</b>
<b>3.5 LATINOS OF GREATER PITTSBURGH.....</b>	<b>23</b>
<b>3.5.1 The Birmingham Clinic population.....</b>	<b>25</b>
<b>3.6 ORIENTATION OF CURRENT RESEARCH .....</b>	<b>26</b>



<b>4.0</b>	<b>METHODOLOGY .....</b>	<b>27</b>
<b>4.1</b>	<b>SAMPLING.....</b>	<b>27</b>
<b>4.2</b>	<b>DATA COLLECTION.....</b>	<b>30</b>
<b>4.3</b>	<b>ANALYSIS.....</b>	<b>33</b>
<b>5.0</b>	<b>RESULTS .....</b>	<b>35</b>
<b>5.1</b>	<b>DEMOGRAPHIC PROFILES.....</b>	<b>35</b>
<b>5.2</b>	<b>SATISFIED HEALTH CARE NEEDS .....</b>	<b>38</b>
<b>5.3</b>	<b>UNSATISFIED HEALTH CARE NEEDS .....</b>	<b>39</b>
<b>5.4</b>	<b>SATISFIED SOCIAL SERVICE NEEDS.....</b>	<b>41</b>
<b>5.5</b>	<b>UNSATISFIED SOCIAL SERVICE NEEDS.....</b>	<b>41</b>
<b>5.6</b>	<b>CHANGES IN ACCESS TO SERVICES .....</b>	<b>45</b>
<b>5.7</b>	<b>SENSE OF COMMUNITY .....</b>	<b>45</b>
<b>5.7.1</b>	<b>Social isolation .....</b>	<b>46</b>
<b>5.8</b>	<b>SENSE OF PERMANENCE .....</b>	<b>47</b>
<b>5.9</b>	<b>RACISM AND DISCRIMINATION.....</b>	<b>48</b>
<b>5.10</b>	<b>FEAR .....</b>	<b>50</b>
<b>5.11</b>	<b>MOTIVATION FOR IMMIGRATION.....</b>	<b>51</b>
<b>5.12</b>	<b>INSUFFICIENT DOCUMENTATION.....</b>	<b>52</b>
<b>5.13</b>	<b>INDIVIDUAL PERCEPTIONS .....</b>	<b>53</b>
<b>5.14</b>	<b>ADDITIONAL OBSTACLES .....</b>	<b>54</b>
<b>5.15</b>	<b>COMMUNITY EDUCATIONAL SESSIONS.....</b>	<b>56</b>
<b>6.0</b>	<b>DISCUSSION .....</b>	<b>58</b>
<b>6.1</b>	<b>SOCIAL STABILITY.....</b>	<b>58</b>

<b>6.2</b>	<b>LEGAL STATUS.....</b>	<b>60</b>
<b>6.3</b>	<b>“SICK” CARE .....</b>	<b>62</b>
<b>6.4</b>	<b>CULTURAL COMPETENCE .....</b>	<b>63</b>
<b>6.5</b>	<b>THE NEW GROWTH EXPERIENCE .....</b>	<b>64</b>
<b>6.6</b>	<b>LIMITATIONS.....</b>	<b>67</b>
<b>6.7</b>	<b>RECOMMENDATIONS .....</b>	<b>68</b>
<b>APPENDIX A: RECRUITMENT FLYER.....</b>		<b>70</b>
<b>APPENDIX B: SYNOPSIS, ENGLISH AND SPANISH .....</b>		<b>71</b>
<b>BIBLIOGRAPHY .....</b>		<b>74</b>

## LIST OF TABLES

Table 1. Demographic Information.....	37
Table 2. Health Care Needs .....	40
Table 3. Social Service Needs .....	44
Table 4. Additional Information .....	55
Table 5. Community Educational Sessions .....	57

## FOREWORD

The collection, analysis, and presentation of the information included in this study were facilitated by the efforts of many people. I would like to thank my thesis committee chair, Dr. Patricia Documét, for her insights and patience in helping me develop the idea and central themes for this study. Dr. Documét read every draft of my evolving thesis and contributed at every stage to my understanding and ability to conduct research within a Latino population. I would also like to thank Dr. Martha Ann Terry and Dr. Kathleen DeWalt, whose experience and expertise enabled me to carry out a study that addressed issues and generated knowledge relevant to both the fields of Public Health and Social Science. Dr. Terry, as well as my dad, Dr. Roger Manela, provided me with superb editorial help, which has enabled me to grow as both a researcher and a writer.

I would like to express my gratitude to the Director of the Birmingham Clinic, Mary Herbert, and to the rest of the clinic staff. They did much more than just tolerate my presence at the clinic every Saturday for months. Their enthusiasm for my study, their support for its objectives, and their genuine interest in its findings were instrumental in allowing me to recruit participants and infusing community members with their sense of the importance of my research. I would also like to thank Dr. Diego Chaves-Gnecco, who helped me recruit study participants at the Birmingham Clinic and who invited me to speak with his patients and their families at Children's Hospital, in order to advance my recruitment of participants. The kindness of the

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## **1.0 INTRODUCTION**

The greater Pittsburgh area has a small but growing Latino population. In the last ten years, this population has grown more than 44% [1]. Unlike other large U.S. cities where Latino and other ethnic groups cluster in specific neighborhoods, the Latino population in Pittsburgh is dispersed, and there is not one specific geographic area in which Latinos are highly concentrated [2]. This means the Latino community in Pittsburgh is less visible, less organized, and less likely to have venues where residents can obtain culturally oriented goods and services [2].

The first effort to quantify and assess the situation of Latinos in Pittsburgh with regard to the availability and utilization of health services was done by Patricia Documét and described in her doctoral dissertation in Public Health. This study identifies several basic health care needs of Latinos that are specific to their culture and situation [2]. The study went beyond economic explanations, examining Latino Americans' culture to determine how it affects access to and use of health care services. Income is a strong determinant of the amount, type, and quality of care, a situation similar to that faced by other minority populations in the United States [2]. Lack of English proficiency and a desire for close, warm patient-provider relations were also characteristic of Latino populations, and were cited as potentially major barriers to Hispanic populations obtaining the kind of care they wanted from mainstream providers.

Data presented to the American Public Health Association in 2006 suggest that the Pittsburgh Latino population has gradually achieved greater stability [3]. The presenters

recommended that future research focus on more qualitative data, collected directly from members of the population about their needs for clinical and social services, and about their experiences gaining access to and utilizing such services. They also pointed to the success of pairing services provided by academic institutions with those offered by community resource centers, and suggested that subsequent investigations of Pittsburgh's Latino population look at data collected directly from health care consumers about which social and medical services are needed in the community [3].

This paper builds upon the recommendations of preceding research, by gathering qualitative information about the health care needs and experiences of Latino residents of Pittsburgh [3, 4]. It seeks to orient the efforts of future researchers toward more systematic collection and analysis of qualitative data, which are crucial for identifying and understanding patterns of health care needs and utilization among the population of largely uninsured members of Pittsburgh's Latino community. This exploratory study does not use a large sample, nor does it emphasize the collection and analysis of quantitative data. Rather, it seeks to uncover and examine issues about the unique situations that Latino immigrants in Pittsburgh may encounter.

A purposive sample was drawn from persons seeking health care services at the Birmingham Clinic, the only free clinic in the area that offers services in Spanish as well as English. Located on Pittsburgh's South Side, the Birmingham Clinic is an ideal access point for reaching Pittsburgh's uninsured Latino population. On Saturdays, from 10:00 A.M. until 2:00 P.M., doctors, medical students, and pharmacists voluntarily provide a variety of bilingual health care services, including general, internal, and family medicine; dispensing prescriptions; and obstetric and gynecological medicine. The clinic draws Spanish speaking patients from all over the tri-county area of Allegheny, Washington, and Beaver.

The interviews I conducted as part of this study collected information about the experience of Latino immigrants accessing health care and social services, and investigate the suggestion that increased economic and social stability are important determinants of health care utilization for Latinos. In addition, I explore several questions found relevant by other researchers about the determinants and nature of health care needs, about barriers to accessing health care, and about the satisfaction Latinos feel with the health care they do receive.

## 1.1 DEFINITIONS

The following terms used throughout this study have specific definitions, which are presented here:

*Latino:* According to the Office of Management and Budget, refers to anyone “of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race” [2].

*Community:* Any group of people unified by a specified shared characteristic, a way of life, or a pattern of behavior [5]. Community identification can occur through multiple nonexclusive avenues, including church membership, neighborhood of residence, location of a particular place and type of business, or membership in a specific and readily identifiable social network [6]. In the case of Latinos, the significant shared characteristic is being of Latin American ethnic origin.

*Social integration:* The level, existence, and quality of social support [7].

*Social networks:* The formal and informal structures within which social support is provided, within which and social interaction takes place [7].



## 2.0 OBJECTIVES

Two major objectives guided both the interview design and data analysis, and provided a framework for presenting the study's conclusions and recommendations.

**Objective #1:** To determine *which of their specific health care and/or social service needs uninsured immigrants from Latin America feel are being met, and which they feel are not being met.*

- How does the length of time one resides in Pittsburgh affect his or her access to health care and other social services?
- What additional services do uninsured immigrants want?
- What kind of community educational or informational meetings do they feel could improve their health or access to health care?
- What barriers might reduce attendance to proposed educational sessions?

**Objective #2:** To determine *how uninsured Latin American immigrants feel that community integration influences access to health care and social services.*

- Do Pittsburgh's Latinos think that increased social stability has enabled themselves to focus on and receive help for a wider variety of health care needs?

### **3.0 BACKGROUND**

Latinos<sup>1</sup> are now the most populous minority group in the United States, and this population is growing faster than any other ethnic group [8]. By the year 2025, the Hispanic population is expected to double, reaching almost 60 million. At this point, Latinos will comprise 18% of the population in the United States.

#### **3.1 HEALTH STATUS**

Like other minority groups, the Hispanic population suffers disproportionately from chronic diseases, such as diabetes and heart disease [9]. Hispanics also have poor health outcomes for illnesses and health problems such as HIV/AIDS and high blood pressure [9]. Latinos do not receive immunizations at a rate equal to that of the non-minority population [8]. According to the Centers for Disease Control and Prevention, violence and accidents are significant causes of mortality within the Hispanic population [10]. In 2002, the average rate of death by homicide for non-Hispanic white males was 3.8%, compared to 13.2% within the Hispanic population. In addition, the death rate due to cutting or piercing, including both intentional and accidental

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<sup>1</sup> The terms “Latino” and “Hispanic” are used interchangeably. The terms “white” and “Anglo”, as well as “black” and “African-American” will also be used interchangeably, and are used to describe populations within the United States that self-identify as non-Hispanic.

injuries, was 1% for non-Hispanic whites and 1.9% for Hispanics. While this difference of 0.9% may seem insignificant, it is important to note that the rate for Hispanics is almost twice that experienced by the Anglo population [10].

In many instances, Latinos suffer from higher rates of disease than Anglos. Cervical cancer incidence rates are almost twice as high for Latinas than for white women [11]. Researchers report breast cancer is the number one cause of mortality due to cancer among Hispanic women, even though the incidence of this problem is higher among non-Hispanic women [12]. Usually, this is because Latinas are likely to be diagnosed with breast cancer only after their cancer has reached an advanced stage. Latinos suffer from morbidity and mortality due to diabetes at a rate almost 30% higher than that of whites [8]. Like breast cancer, early detection and treatment are key to saving the lives of people with diabetes. Also, each subsequent generation of children experiences higher rates of obesity and asthma, as each generation becomes more removed from their culture of origin and adopts the negative behaviors typical in unhealthy environments characteristic of low-income American families [13, 14].

It is important to mention that although Hispanic persons usually suffer poorer health outcomes than Anglos, there are also instances that have been described as an “epidemiologic paradox” [15]. One such paradox is the pattern of infant mortality rates among the Latino population. Because Latinos often experience socioeconomic conditions similar to blacks, Latino infant mortality rates might be expected to be similar. However, the infant mortality rate among Hispanics is actually more similar to that of white Americans [15, 16]. A California based study comparing black, white, and Hispanic mothers found that black and Hispanic women had similar rates of teenage motherhood, non-married childbearing, and underutilization of prenatal health care. However, the rate of adverse infant health outcomes for black babies was

nearly twice that of both white and Hispanic infants [16]. Perinatal outcomes for immigrant groups are frequently more successful than later generations [15], which may account for this finding, although the generational status of mothers was not discussed in this particular study. Unexpectedly low infant mortality rates among Latinos warrants further exploration, and researchers have suggested several explanations, including cultural differences in diet, the nature of Hispanic family and social support networks, and the absence of yet unidentified risk behaviors [15].

Other health outcomes among the Latino population not consistent with limited access to care include the incidence and mortality rates of cancer. The four types of cancer that cause the majority of deaths are breast, prostate, lung, and colorectal. Hispanics have lower rates of incidence, and often mortality resulting from these four cancers [18, 19]. While the Hispanic population is generally younger than the general population, and this may account for a portion of the comparatively lower rates, Latinos have a 33% lower age-adjusted cancer incidence rate than non-Hispanic whites, and a 38% lower age-adjusted cancer mortality rate as well [19]. In contrast, Hispanics do suffer from higher rates of incidence and mortality from other cancers, specifically those caused by specific environmental or infectious agents, such as stomach, liver, cervical, and gall bladder cancers [17]. Cancer mortality rates may be heightened by Latinos' limited access to health screening services, and by the fact that the later a cancer is diagnosed, the lower the chances of survival. Also, anecdotal evidence suggests that sometimes immigrants may return to their country of origin after a cancer diagnosis, which could also skew mortality rates [18]. Furthermore, the extreme diversity within the population categorized as "Hispanic" may account in part for rate inconsistencies, due to differences in genetics, diet, behavior, and other cancer risk factors [17].

### **3.2 ACCESS TO HEALTH CARE**

There is strong evidence to suggest that young adults, ages 19 to 30, face the most barriers accessing health care in the United States, regardless of race, ethnicity, or gender [9]. Unfortunately, young adulthood is the period in a person's life when long-term health behaviors become well-established and reinforced, and when preventative health care services can have the most impact on longevity. The potential impact of not gaining access to health care is especially grave for young adult Hispanics. There are not adequate data on the proportion of young adult Latinos who have limited access to health care, or on the factors that limit their access to care, because there has not been enough research on this issue among this specific group (Latino adults between the ages of 19 to 30 years old) [9]. The proportion of Latinos who suffer from a range of health care problems indicates that it is especially important for young adult Latinos to obtain preventative care and health screening services.

Recent immigrant status is one factor that is associated with limited access to health care. According to one study, over 90% of Hispanic young adult respondents reported being recent immigrants, living in the United States for less than five years. Furthermore, Latinos who have lived in the U.S. for more than fifteen years continue to report having only limited access to health care. An immigrant's access to health care does improve, however in a limited capacity. Researchers agree that it is reasonable to assume care is most limited for recently arrived immigrants [9].

One study that investigated the influence of generational status on access to health care among Mexican American children found that almost half of first-generation children born in the U.S. to Mexican American parents had not seen a doctor within the past year [20]. Both Mexican American and non-Hispanic black children had similarly low rates of reporting a ‘usual’ source of care, and these rates were much lower than those of white children. Mexican American children still had limited access to health care after controlling for socioeconomic and health insurance status. First generation Mexican American children also experienced more barriers to accessing care than those from second or third generations.

Analysis of survey data reveals that while most barriers to accessing health care are related to income, citizenship, and marital status, when these factors are controlled, Hispanics still have disproportionately lower access to care than whites, and among Hispanics, access to care varies according to national origin [21].

### **3.2.1 Perspectives on barriers to accessing health care**

Barriers to health care can be viewed from a number of perspectives. Some barriers to accessing health care are organizational or structural, such as not having insurance or not speaking English. Others are more personal, such as preferring a warm close relationship with the care giver [8]. An example of a barrier which may be both personal and organizational is the fact that many Latinos find it difficult to get to and from appointments with health care providers at times when clinics are open, either because of their work schedule, or because they lack transportation [8]. The lack of viable public transportation options is a structural barrier that contributes to this problem.

Latinos are more likely than whites to visit transitory, less permanent health care establishments, such as mobile clinics or emergency rooms. Accessing the health care system through these kinds of settings makes it difficult to receive continuity of care, since this is not the main orientation of these delivery sites. It should also be noted that less permanent, less institutionalized health care delivery sites have recently been at greater risk for losing funding than more institutionalized, mainstream venues of care, which threatens the stability of Latinos' most frequently accessed health care delivery sites [8].

Many Latinos find it difficult to gain access to providers of specialty care. While 8% of whites report "major problems" obtaining referrals to specialty care, and 16% of blacks find it difficult, 22% of Latinos report difficulty getting referrals to providers of specialty care [8].

Barriers to health care can be assessed from both individual and societal perspectives. Attitudes and beliefs are generally considered individual characteristics. Past experience with illness is also an individual determinant of a person's sense of urgency when seeking health care services [21]. Whether or not one has health insurance can also be considered an individual determinant of access to care [21]. But, when a whole population is systematically denied the option of health insurance, or is limited by poverty and discrimination from obtaining insurance, it is a societal problem. People's perceptions of what ails them, how serious their health problems are, the prognosis for their problems, and the amenability of those problems to treatment are individual factors that shape how and from whom people seek health care. However, the way an illness is diagnosed, how and to whom it is referred for treatment, the nature and extent of the treatment, and the kinds of health care providers that typically treat the problem are all characteristics of the particular model of treatment that is applied, that is

determined at a societal or organizational level, with some local variation due to the availability and cost of health care resources.

In addition to the fact that individual, societal, and organizational factors determine access to and utilization of health care services, the perspectives of both providers of health care and the recipients of that care interact to determine access to and utilization of health care services. The level of agreement between providers and recipients regarding the most effective manner of health care delivery is a significant factor that can either promote access to health care services, or present a barrier to accessing services [21].

More and more health care professionals are recognizing the importance of improving communication with their patients to ensure that consumers understand their diagnoses and recommendations. Without this kind of communication between consumers and providers of care, it is unlikely that patients will understand and follow the recommendations of medical providers [22]. Some suggest that community-level interventions, reinforced by the social networking characteristics of Latino populations, would be especially effective in building consumers' understanding of the perspectives and information offered by mainstream health care providers [22, 23]. The concept of "collective efficacy" has been used to describe the "combination of social cohesion and shared expectations for beneficial action on behalf of that community" [23]. This mechanism can be used to improve health outcomes for the community as a whole, as well as to increase the health care compliance of individual members of the community.

Health care seeking behaviors, such as locating and returning to a consistent source of care, have been increasing among all populations in the United States. However, over the last 10 years, the increase for minority groups has been less dramatic than that of the majority. This



phenomenon among Hispanics may reflect the collective, compounded impact of barriers to access discussed above, and can be perceived as an overall societal barrier to health care for the Latinos [21].

### **3.2.2 Health insurance**

The Kaiser Family Foundation reported in January of 2007 that at the national level, Hispanics are the ethnic group least likely to have health insurance coverage. Anglos are the group most likely to have insurance, with 69% of the white population having employer-based insurance, compared to 40% of Hispanics; only 13% of Anglos are completely uninsured, compared to 34% of Hispanics [24]. Of the 45 million uninsured persons in the United States, about a quarter are Latino [8]. According to the U.S. Census Bureau, in 2002 nearly 90% of whites had health insurance; almost 80% of African Americans reported having health insurance, but less than 70% of Latinos reported having such coverage [12].

The fact that the Latino population is less likely than the white population to have health insurance is no doubt related to Latinos' low socioeconomic status relative to whites [8, 9, 25]. For the most part, medical insurance in the United States is employer-based. If an employer provides health insurance, a worker and his or her family are likely to be covered. If an employer does not provide health insurance, a person and his or her family are not likely to be insured. Of the 11 million uninsured Latinos in the United States, 9 million report that at least one family member is employed full-time [8]. While most Latinos report that they are employed, less than 60% report that their employers offer them the option of health insurance [9, 25]. This may be because persons with low income jobs are likely to work in small businesses that do not offer health insurance.

On the other hand, there are considerable data showing that whites are more likely to be offered health insurance, even when they work jobs similar to those of Latinos [9]. Furthermore, the high proportion of Hispanics without health insurance cannot be attributed to any type of resistance within the population to purchasing health care coverage. When offered an insurance option by employers, Hispanics are equally as likely to enroll as whites [9]. There is some evidence that the lack of health insurance among Latinos is a problem that is getting worse, not improving. The Center for Studying Health System Change found that the overall rates of enrollment in health insurance for Hispanics may be falling for “unspecified reasons.” In 2001, 48% of Hispanics held employer-based insurance policies, while two years later only 40% of Hispanics reported having insurance [9].

### **3.2.3 Immigration status**

An estimated one third of Latinos in the U.S. are born outside the United States [9]. Current figures on the number of legal residents are rough estimates, and data on illegal residents are even less reliable. Some researchers suggest that the presence of current and complete documentation is the single most important factor in determining access to health care for Latinos [26].

### **3.2.4 Discrimination and prejudice**

Latinos’ acceptance in the United States is limited by discrimination [27]. Many Latinos are discriminated against because their appearance: “bronze” or dark skin, dark eyes and hair, and facial features that reflect characteristics of the indigenous people of Latin America. In both the

United States and in Latin America, there is a tradition favoring people with lighter skin. In Latin America, this reflects a colonial heritage during which elites traced their origins to Spain and other European countries and saw their lighter skin and absence of the features of indigenous people as a mark of elevated social status. Unfortunately, remnants of these attitudes continue [2, 27]. The phenotypic appearance that makes Latinos targets of racism among Anglos is used as a basis for racial prejudice and social elitism by other Latinos [27]. Speaking with an apparent Spanish accent is also used as an identifier of Hispanic persons as targets of racism [2].

### 3.2.5 Cultural orientation to health care

An important cultural factor to consider when looking at the way Latinos relate to health care is that Latinos often prefer to develop strong, long-lasting, close relationships with health care providers. This is not always possible within the mainstream system of health care in the United States [2, 12]. There are also certain cultural features commonly associated with how Latinos communicate with and orient themselves toward care givers. These include *fatalismo* (fatalism)<sup>2</sup>, *familismo* (familism)<sup>3</sup>, sense of community, historical and cultural orientation to Catholicism, respect for the authority of physicians, and *personalismo* (personalism) [28, 29].

The expert-recipient model characterized by considerable social distance, typical of doctor-patient relationships in HMO-style and other U.S. health care settings was designed for middle to upper-class Anglos. This does not fit well with the type of relationships many Latinos prefer to have with their health care providers [22]. This is an example of how lack of cultural

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<sup>2</sup> The idea that an individual can do very little to change their fate or to alter God's plan [29].

<sup>3</sup> The sense of collective loyalty to one's family, which may overshadow one's responsibility to themselves [30].

competence among health care providers can present very real barriers to Latinos seeking and obtaining health care [8].

Over the last thirty-five years, social researchers have looked at the ways Latinos relate to health care from a number of perspectives. In the 1970s, anthropologists and ethnographers favored a cultural explanation based on what was seen as typical of the way Mexican Americans relied on traditional *curanderos* (folk healers) for much of their health care [25]. It was thought that Mexicans in the United States were reluctant to use mainstream health care systems because of strong ties to their ethnic communities and local health care networks. Social researchers thought that Mexican Americans were willing to use Anglo doctors only as a last resort. These researchers paid little attention to the barriers that limited the access of many Mexican Americans to mainstream health care institutions. Issues such as poverty, lack of health insurance, limited English proficiency, and lack of transportation prevented many Mexican Americans from accessing mainstream Western doctors until their health problems were quite serious, and often beyond the point where treatment could be optimally effective. This reinforced the belief among some Mexican Americans that using Anglo doctors was a sure route to death or disability, and further alienated segments of the Mexican American community from mainstream health care institutions and providers [25]. Anthropologists focused on what they saw as a preference among Mexican Americans for traditional medicine and discounted the effect of barriers that limited access to mainstream health care institutions. Some anthropologists suggested that integrating *curanderos* into mainstream medical institutions would encourage Hispanic populations to seek help from Anglo doctors before their illnesses had progressed to the point where treatment would no longer be effective. Today, this perspective seems simplistic and outdated [21].

In the 1980s, social researchers suggested that Hispanics favored home remedies and traditional medicines over prescription drugs [25]. However, the reason for this was never fully explained. Some suggested that home remedies and traditional methods of healing were familiar and were reinforced by the ethnic identification of Hispanic people. However, it is just as likely that many Latinos did not have sufficient access to mainstream providers of medical care nor to the funds necessary to purchase expensive prescription drugs [25].

Today, health care providers are more aware that Latinos often take a pragmatic approach to health care, accessing services from both mainstream and traditional systems of health care. Public health planners no longer assume that Hispanic consumers have any problem integrating services from traditional and mainstream health care providers, nor do they view this practice as somehow contradictory or problematic [31].

### **3.2.6 Acculturation, assimilation, and language**

Acculturation and assimilation are frequently cited in public health publications as having an impact on access to health care. Teske and Nelson differentiate acculturation from assimilation [32]. They agree that for assimilation to occur acculturation must have begun. However, assimilation is not necessary for acculturation. Furthermore, they note that assimilation assumes a unidirectional change, whereas acculturation is a two-way process: not only does the immigrant group integrate into the host country's way of life, but it also retains and shares its culture of origin with the new country. In general, acculturation is seen to be a less wrenching process than assimilation, because it does not entail total abandonment of one's previous way of life [32]. Both acculturation and assimilation are dynamic processes which can occur at the individual and/or community level [32].

The importance of acculturation as a condition for benefiting from mainstream U.S. health care services is often illustrated by researchers. An argument made is that as Latino immigrants increase their levels of interaction with the institutions and culture of the United States, they gradually become acculturated, and over time, their patterns of behaviors become more mainstream, and their use of available health services increases [33].

Researchers often use language preference as a significant indicator of cultural integration [34]. Results have shown that language barriers do adversely affect access to and satisfaction with health care among Latinos [28]. Latinos comfortable with English have patterns of health care utilization similar to the population as a whole. For example, English fluency has been positively associated with Hispanic women's desire to take an active role in their health care decisions and with their willingness to ask questions and seek information from health care providers [28].

Latinos who do not speak English are more likely to come from lower socioeconomic brackets [12]. Their limited English proficiency also increases the likelihood that they will struggle with bureaucratic processes that could open the door of access to care, such as filling out insurance forms and scheduling appointments [8]. Language barriers also make it difficult for Spanish speakers to understand their diagnosis, follow instructions for taking medication, and pursue recommended follow-up care.

However, while some researchers have demonstrated that acculturation may have positive impacts on one's utilization of health care, and thus on one's overall health, it can also have detrimental impacts on health behavior. For example, one study found that among Hispanic women, increased acculturation was accompanied by increased alcohol use, and for

both men and women increased acculturation included a disruption in following more traditional, balanced, and healthy diet [35].

While it is important to consider how acculturation and assimilation have been cited as explanations of patterns of access to health care and social services, there is doubt that researchers should continue using ‘acculturation’ and ‘assimilation’ to measure social integration, or as measurable variables in health research [36].

The measurement of acculturation and assimilation pertains to the nature of conceptual definitions, which are presumptive and vague. Hunt, Schneider, and Comer (2004) scrutinized 69 works published about acculturation among the Hispanic population between 1996 and 2002, and in the majority of articles the words “acculturation,” “culture,” and “mainstream culture” although frequently used, are rarely defined [36]. This study also concluded that broad generalizations characteristic of assimilation and acculturation studies do not pay sufficient attention to the cultural differences between Hispanic populations living in the United States.

Hunt, Schneider, and Comer also point to the presumptive dichotomy inherent in the concept of acculturation, which assumes that individuals move along an axis from “less acculturated” to “more”. This concept perpetuates the assumption that Latin American and Anglo American cultures have been historically separate. Mexico and the United States share a long history, especially in the Southwestern United States, where Anglos and Hispanics have shaped the local culture simultaneously. In this context, a simple bipolar concept of acculturation does not apply [36].

While most of the authors who used the concept of acculturation point to a relationship between increased acculturation and health outcomes, 61% claim that low acculturation correlates with better health, while the other 39% find that low acculturation is more consistent

with poorer health outcomes [36]. Even if researchers cannot agree on the conclusion, it is still problematic that retention of Hispanic culture must be either a “source of dysfunction” or, in contrast, a “therapeutic panacea” [37]. Perhaps it is best to simply recognize that language use and cultural adaptation do have an impact on access to health care, rather than completely collapse the concepts inherent in the process of acculturation into measurable, determinative variables.

### **3.3 A LEGACY OF LIMITED OPPORTUNITY**

Even though Latinos are the fastest growing minority in the United States [3, 9], they face many injustices in the United States. Much of Latin America was economically exploited and politically destabilized, first by European colonialists and later by capitalist enterprises based in England and the United States. As a result, many of today’s immigrants from Latin America have come north to escape or improve upon unfavorable circumstances at home [38]. However, despite the promise of greater opportunity in the United States, many Latinos face significant barriers to full participation in American society. This includes access to and utilization of the U.S. health care system.

It has been well documented that minority populations, regardless of race, ethnicity, or socioeconomic status, face significant barriers when attempting to access health care [25, 39]. This is true for recent Latino immigrants to the United States, for other recently arrived immigrant groups, and for the Latino groups in the Southwest who have been present for over 400 years [9, 27]. Despite advanced medical technologies and excellent health care services in the United States [21], Latinos have not benefited as much as the rest of the population from



advances in health care and medical treatment. Reasons for this include lack of insurance, too few health facilities that cater to the needs of the Latino population, limited transportation, provider's lack of Spanish proficiency, lack of child care, and limited ability to take time from work [8].

The low socioeconomic status of Latinos, relative to the Anglo population, is often cited as a major reason for their limited access to health care. Latinos are twice as likely as whites to live in poverty [8]. In general, adults with low incomes are most likely to postpone needed medical care, such as filling prescriptions or visiting the dentist [39]. Unfortunately, the poor often have both chronic and acute health problems that should not wait for treatment [39]. Furthermore, Latinos are less likely to have a usual source of health care [9, 12, 25], and, people of Hispanic origin are less likely than whites to use preventative health or dental services [9, 25].

Health disparities characterize Latinos' access to and utilization of health care services relative to Anglos, even when socioeconomic situation and insurance status barriers are removed. This suggests that cultural factors among Latinos limit their access to and utilization of health care, independent of socioeconomic status and insurance coverage [21]. Furthermore, lack of culturally appropriate health services limits their satisfaction with the health care services they do receive [9].

In addition, the work some Latinos do also can limit their use of health care services. Among migratory farm workers, many of whom are Latino, transitory lifestyle makes it difficult to maintain an ongoing relationship with a primary health care provider and limits the likelihood that health care, especially preventative care, will be coordinated or consistently maintained over time [12].

Another factor that contributes to Latinos' limited access to health care is that minority groups make up 30% of the U.S. population, yet have only minimal representation in the fields of medicine and other health care professions. The picture is no better when we see the provision of health care and public health services from a societal perspective. Only 17% of public health officials are from a minority group; less than 16% of academic positions in public health are held by minority persons; only 3% of medical school faculty members are nonwhite; and less than 2% of senior leadership positions in health care are held by persons from minority groups [8]. This underrepresentation poses a barrier to health care access and utilization by Latinos. Without a proportional number of Latinos in the health care fields, the system is less likely to respond to the needs of the population in a manner that is culturally appropriate.

### **3.4 COMMUNITY INTEGRATION AND SOCIAL SUPPORT NETWORKS**

While the concept of social integration has been well studied, there is little discussion of the relationships among social stability, community integration, and access to and use of health care by a Latino population. Due to this paucity of data, I have chosen to examine aspects of these constructs for which data do exist, and which seem to be most significantly related to health care access and outcomes. I have paid special attention to social support and social networking as indicators of community integration and social stability.

Social networks are shaped and defined by the size and nature of one's community, and by the degree of one's social integration and participation in that community [25]. Social support is a transactional exchange between an individual and his or her environment. The community in which support systems exist provides both formal and informal avenues for building and

maintaining social relationships. These relationships increase an individual's feeling of connectedness, and the perception that support is available if and when it is needed [6]. Social support has been shown to be associated with positive health outcomes, regardless of one's ethnic identity and across a range of health problems [6]. For example, a person's ability to depend on a spouse, on members of a church, or on other kinds of social affiliations can have a profound influence on his or her health outcomes.

Social networks and shared perceptions profoundly influence ideas and approaches to treating both mental health and physical health problems. Support networks also help reduce morbidity and mortality, and decrease the impact of stress [7, 22]. For example, people with few intimate relationships, low levels of social support, and diffuse social networks have a relatively high incidence of depression [40]. Support networks generate preventative, therapeutic, and comforting processes that diminish the effects of illness, ease transitions, and mitigate the impact of stressful and traumatic life events [6]. People not well integrated into the life of their community, and those who have weak social networks, are at a relatively high risk of prolonged morbidity and mortality, even when they do not have major health problems [22].

Hispanic people tend to rely on their family for support before turning to other social affiliations [25]. Researchers in Arizona report that the state's Latinos usually depend on those close to them to help decide when it is time to seek medical care [41]. This finding has also been observed within Pittsburgh's Latino population [2].

Another group of researchers created a social integration index, based on participants' reported number of close friends or relatives, presence/absence of weekly contact, and reported weekly church attendance [42]. This index was averaged for four U.S. Hispanic groups: Mexican-Americans, Central Americans, Cuban Americans, and Puerto Ricans. It was found

that Mexican-American women have the highest levels of social integration, and they also are the group of Latinas most likely to have had recent cancer screening tests [42]. This effect was slightly more significant for Pap smear tests than mammography.

Garbers and Chiasson, in a study of Dominican and Mexican families in New York, found that social networking and support systems among women are effective mechanisms for transmitting health care information [43]. For example, even though older women had relatively low levels of education and poor access to health care, they were significantly more likely to perform breast self-examination after discussing this process with other female family members. These results suggest that kinship and social networks can effectively disseminate health care information in underserved communities, even when more typical and formal methods of health education may not be effective [43].

### **3.5 LATINOS OF GREATER PITTSBURGH**

Allegheny County's Latino community is thought by most to be so small that it is considered "invisible." However, the Latino population of the greater Pittsburgh area is growing rapidly. From 1990 to 2000, Allegheny County's Latino community increased by over 44%, from 7,749 to 11,166 [1]. While census data do not provide a more recent count, a proportional population projection based on birth rate increases conservatively estimates there are 20,000 Latinos in Allegheny County (P. Documét, personal communication, April 24, 2007).

One indication of growth in the Latino population is the number of patients that attend the Birmingham Clinic, which serves a significant cross-section of the uninsured Latino community. On Saturdays, interpreters, bilingual doctors, pharmacists, and other medical staff

volunteer their services. In 2003, 120 Spanish speaking clients sought health care from the Birmingham Clinic. In 2005, this number had grown to 325, and in 2006 it was 415. This increase may reflect improved outreach efforts by and on behalf of the clinic, and better strategies for communicating with the Latino population about the existence of the Birmingham Clinic and the free, bilingual services it provides. In either case, growth in utilization of the clinic reflects the community's increased need for services.

Despite this community's rapid growth, greater Pittsburgh's Latinos are not concentrated in one or two neighborhoods, as is the case in many other areas of the United States. The Kaiser Foundation compared access to health care for "new growth" communities to "major Hispanic centers". A new growth community is one in which the Hispanic population is highly dispersed, yet growing rapidly. A major Hispanic center is an area in which there is a stable and flourishing Hispanic community, such as New York City, Los Angeles, Miami, and Chicago. One of the characteristics distinguishing new growth from major centers was the limited availability of safety-net providers within new growth communities. This was determined by residents' proximity to community health centers or hospitals [44]. Pittsburgh's Latino population may be described as a "new growth community," since the dispersion of the Latino community helps maintain the illusion that there are no Latinos in the Pittsburgh area. In actuality, there is a significant Hispanic population spread throughout the city and tri-county area of Allegheny, Beaver, and Washington [2]. The fact that Pittsburgh's Hispanic population is not organized as a whole but exists in smaller separate groups, is itself a barrier that limits the availability of and access to health care [2].

### **3.5.1 The Birmingham Clinic population**

In 2005, 83% of attendees at the clinic, including Latinos and Americans, were uninsured (M. Herbert, personal communication, February 5, 2007). While a small number of persons who attend the clinic have some form of insurance, such as Medicare or private insurance, the majority of Latinos who use the free services offered by the clinic have no health insurance coverage. It is reasonable to infer that an even greater proportion of Hispanic clinic visitors are uninsured compared to non-Hispanics, due to the bureaucratic nature of employer and government based insurance policies. For example, lack of English proficiency poses a major barrier to completing the necessary paperwork when enrolling in a health care program, and absence of complete legal documentation prevents an immigrant from even applying for health insurance.

The most recent data available indicate that 38% of Latinos in the Pittsburgh area have no health insurance [2]. Of those who attend the Birmingham Clinic, 70% do not have a social security number, which is necessary to obtain most health care and social services in the United States. In 2004, just under two thirds of Latinos attending the Birmingham Clinic were from Mexico, with the rest coming from other Latin American countries. Approximately 84% find out about the clinic from friends or through their church (M. Herbert, Clinic Director, personal communication, March 7, 2007).

Comparing data from 2003 with data from 2005 shows that, over the years, many of the Latino patients who continue to use the clinic have achieved greater residential stability, in terms of renting living space as opposed to staying with friends [3]. The number of people living in one household has declined, while family size has generally increased. Median income has

increased somewhat, and more patients are reporting visiting the clinic for a physical exam or other preventative procedures, as opposed to seeking help only for specific urgent problems.

### **3.6 ORIENTATION OF CURRENT RESEARCH**

This paper addresses many of the issues facing the Latino population of Pittsburgh. Latinos often face higher disease incidence, and greater barriers to care than the population majority. The study on which this paper is based focuses on identifying the social and medical needs of uninsured Latinos who attend the Birmingham Clinic, concentrating on young adults because they are more likely than children, or the elderly, to encounter difficulty obtaining needed medical care. This paper focuses on immigrants from Latin America, as opposed to Latinos in general, because immigrants face more barriers to accessing care. One aim of this study is to collect information about whether or not Latin American immigrants feel that their living situation has become more stable. Another goal is to learn more about the levels of social support and community integration Birmingham patients experience, and how these factors have affected patients' access to health care and social services.

## **4.0 METHODOLOGY**

The paper is based on a set of interviews conducted with a sample of Latin American clients at Pittsburgh's Birmingham Clinic. The research methods used in this study are consistent with those used in many other qualitative studies. The main method of data collection was open-ended interviews, combined with a small amount of ethnographic observation. Analysis was performed by mining interview transcripts for themes, and individual stories were used to highlight similarity and diversity of experience.

While I am a non-Hispanic woman and my first language is English, I have studied Spanish for more than a decade, have spent considerable time in Latin America and have worked in Hispanic communities in the United States. I feel comfortable in the context of Latin American culture, and enjoy using Spanish as my second language.

### **4.1 SAMPLING**

The purposive sample in this study consists of eight Latin American immigrants, seven chosen from the clients of the Birmingham Clinic, and one from Children's Hospital. Criteria for selecting potential interviewees were that they be young adult immigrants from Latin America who either have no medical insurance, or are underinsured and thus rely on the clinic's free services. Latinos born in the United States were not eligible for participation. Persons from



especially vulnerable populations, such as the mentally ill, were not eligible for the study. The Institutional Review Board at the University of Pittsburgh approved the study (IRB #0702017) before any recruitment of respondents or data collection began.

I sought both male and female participants, with length of time in the United States ranging from just a few days to years. Because most of greater Pittsburgh's Latinos are Mexican, I wanted to include respondents from Mexico, as well as representatives from other Latin American countries. I intended to recruit respondents who reported a range of occupations and educational levels. A sample with these characteristics would represent the diversity found within the Hispanic population. I initially planned on recruiting ten to twelve participants, but later found that eight to ten was more realistic. I was in fact only able to recruit eight.

The Birmingham Clinic on Pittsburgh's South Side neighborhood was used as the primary recruitment access point. The University of Pittsburgh School of Medicine maintains a standing relationship with this clinic; for several years, bilingual students from the medical school have been volunteering their services to the clinic on Saturday afternoons. This previously established trust between the clinic and university allowed me to build upon that relationship, extending it to myself, a student of the University's Graduate School of Public Health. In addition, my previous year volunteering within the Latino community in the area of health promotion verified my commitment and legitimized my intent to work within the population at the clinic. I initially approached the clinic's director with a research proposal, and she agreed that the project would be mutually beneficial for both the academic institution, and for improving the health of the community.

Patients at the Birmingham Clinic fill out an intake form when they arrive. I assisted with this routine process, using these forms to determine a participant's eligibility based on his or

her basic demographic information. I approached potential participants explaining briefly the study's purpose, and asked if the potential participant would agree to schedule an interview for another time, or during and after their current clinic visit.

Initially, respondents were recruited exclusively at the Birmingham Clinic. When recruitment proved to be slow, Dr. Chaves-Gnecco, a volunteer at the clinic, invited me to recruit participants at a Tuesday clinic where he provided bilingual pediatric services at Children's Hospital. The doctor, a Latin American immigrant himself, introduced me to potential participants, allowing me to describe the study to parents who were waiting for their child's appointment. I recruited one participant at Dr. Chaves-Gnecco's Tuesday clinic.

Most of the people I approached declined an interview. Some directly cited work or family obligations. However, most who refused did so indirectly by responding that they would call me, but not following through. Patients who intended to participate typically scheduled an appointment immediately to meet with me later in the week. I left flyers with my contact information at the clinic, and I asked participants to give flyers to friends, but I did not recruit any participants via these flyers (see Appendix A).

I considered whether the lack of some form of compensation for participants had an effect on my ability to recruit participants. Generally speaking, expecting compensation is not yet the standard within this community, as it is for African American communities who participate in research studies (P. Documét, personal communication, March 25, 2007). However that is not to say that lack of compensation can be completely ruled out as one reason for the low numbers of study enrollment. It is also possible that sensitivity of undocumented persons, and their fear of deportation posed limitations to my ability to recruit. It is most likely that members of this community are busy working, and have many other priorities to attend to

before being able to commit to an hour-long conversation with a stranger for which they may never receive direct benefits.

## **4.2 DATA COLLECTION**

Before each interview, I handed the respondent a bilingual document summarizing the study's intent, its potential risks, and explanation of benefits. Prior to audio recording, respondents created a false name that was attached to the interview number, to preserve anonymity, and guarantee confidentiality. This study presented no foreseeable risks. No form of compensation was offered to participants, and there were no direct benefits. Respondents did know that summaries of the information gathered would be shared with local service providers, and could benefit the Latino community as a whole. The document I provided participants served as a consent agreement, and was read aloud in Spanish, word for word, at the beginning of each interview. I provided my name and contact information, as well as information about the study's supervisor.

Interviews consisted of qualitative questions designed to elicit personal information relevant to the main research objectives [45]. Interviews allowed for the exploration of the social and cultural contexts in which respondents lived, and how those contexts shaped their access to health care. All interviews were recorded on a digital voice recorder, and I took notes throughout each interview. Interviews with female respondents were conducted at the respondent's home, at the clinic, or at some other convenient and appropriate site in the community. Interviews with male respondents were conducted either at the clinic or at some

convenient and appropriate site in the community. It was not considered appropriate for me, as a female, to conduct interviews at the homes of male respondents.

When interviews were conducted in the participant's home, data collection strategies included observation of the home itself, as well as any social interactions which occurred among family members during the interview [46]. I recorded additional notes immediately following each visit, and these observations provided data that complement the information obtained during the interview, enriching my understanding of respondents' social contexts.

Interviews were conducted within a flexible framework and addressed each of the research objectives [45]. There was a set list of questions that I wanted to discuss, but allowed for natural diversion conversation which could potentially add insight to the information I was gathering. The interviews were conducted in a conversational manner appropriate to the collection of qualitative data from an ethnographic perspective [46]. The main focus of the interview was on what immigrant Latino consumers of health care saw as their health care needs, and how they felt about the health care they sought and received. Emphasis was placed on uncovering respondents' perceptions of the nature and severity of any barriers they encountered accessing the kind of health care they felt they needed and wanted.

The semi-structured interview format allowed me to guide the discussion toward the research objectives, while maintaining a dialogue in which respondents freely shared their feelings and observations about the health care system [45]. I aimed to create a supportive environment, in which respondents were able to reinforce answers with narrative stories. My goal was to encourage participants to feel relaxed and to give candid responses, rich in detail and replete with examples. Following a brief reintroduction and a few minutes of small talk, interviews began with simple demographic questions and evolved into more open-ended

exploratory questions. When participants revealed significant information relevant to the main research questions, I used focused probes to elicit additional data.

Interviews were conducted in the respondent's language of choice. Most respondents spoke only Spanish. Some respondents were also proficient in English, and these interviews were conducted with these participants using both languages.

The following series of questions (translated back to English) are typical of what I asked respondents, in order to expand upon the main research objectives:

- How are your medical care necessities realized through the services offered at the Birmingham Clinic?
- What other health services would you like that the clinic does not actually offer?
- What social service needs are not currently satisfied?
- How long have you lived in the Pittsburgh area?
- How have your medical care needs changed since your relocation?
- Would you consider attending a community educational session, in Spanish, where topics of medical care or other problems would be discussed?
- What would you like to learn about?
- Where and when should we meet?
- What could presenters do to help you attend?

When respondents provided only short answers, I encouraged them to share more information by asking “why,” “how,” or “can you tell me more about that?” If respondents did not completely understand my question, I provided examples, while taking care not to lead respondents. For instance, if a single man with no children and a steady job did not understand what was meant by “social services,” I might have used the example of “child care” or

“employment seeking assistance” to illustrate the type of answers I was looking for. Knowing that he had employment and did not need child care, I could demonstrate the nature of social goods without giving him a potential actual response.

Initially, respondents were not asked about their educational levels. During two interviews, respondents were not asked about the community educational meetings.

In general, not all participants were asked exactly the same questions, partly because of the nature of open-ended, conversational interviews, and partly due to insights I developed throughout the course of the study. For example, fear and racism were not topics that I initially incorporated into my line of questioning. After speaking with María (all names are pseudonyms), it became apparent to me that these issues had a profound impact on access to services. From interview three and beyond, respondents were asked directly about these issues, in case these ideas did not manifest themselves during the natural course of conversation. I found that incorporating these concepts into my questions was extremely beneficial, as most participants had an experience to share that related to at least one of these barriers to access.

### **4.3 ANALYSIS**

Immediately following each interview, the digital recording was uploaded for transcription. When participants responded to specific research questions, I transcribed our dialogue word for word. When the interview became more casual and conversational, and less relevant to the study, I summarized the discussion. For this reason my data exist in both languages, featuring the language of the discussion, as well as notes in the language with which I am most comfortable, English. All interviews were transcribed by me, and translated by me.

The first level of analysis occurred during transcription. I typed direct answers to specific research questions in bold, so that these answers would be easily identifiable at a later time. Also, I typed particular recurring themes in a specific font colors. The second round of analysis occurred when I first read transcriptions. Each theme was assigned a code, and a unique color. Recurring themes provided evidence of similar experience accessing health care. Diversity in responses provided anecdotal evidence of the individualized range of experiences. I created a coded list of relevant responses, which was illustrated by personal stories which supported participants' ideas. I read and reread the transcriptions, and temporarily saved recordings, in the event I needed to refer back to the original conversations. Because of the small number of participants in this study, data analysis was done without a computer-based qualitative analysis program.

## **5.0 RESULTS**

Over the course of two months, a total of eight participants were interviewed. These respondents came from a range of demographic backgrounds, and reported a wide variety of experiences accessing health care and social services in the United States.

### **5.1 DEMOGRAPHIC PROFILES**

The demographic profiles of each respondent can be found in Table 1. Four participants were male, and four were female. All participants can be described as “young adults”: three were 26 years old, two were 27, and one respondent each was age 29, 31, and 44. Two respondents reported coming from Mexico City. Two more respondents come from Toluca, Mexico. One participant came from the countryside in Michoacán, Mexico. One respondent came from Guatemala, one from Peru, and one from Argentina. One subject self-identified as “Hispanic,” one as “Argentina,” (Argentinean) and one as “Peruana” (Peruvian). Two participants identified themselves as “Mexicano” (Mexican). One subject told me he “didn’t care,” how he was identified, and went on to say that while he feels he is “Mexican-American,” he believes that others (Americans) think of him as “just Mexican”. Two participants did not self-identify.

Four participants spoke Spanish exclusively, and two were completely bilingual. Another two reported knowing “a little” English.



The subjects resided in a variety of living situations. Two single adults lived with friends, one single adult lived with his brother. Three women lived with their children and spouses; two of these women also lived with additional family members, such as parents or cousins. Additionally, there were two adult men who resided with their parents and siblings.

Of the five participants from whom I requested educational level, one reported that he did not finish high school. The other four completed high school. Two participants started but did not finish college. Finally, one participant held a Master Degree and two Bachelor degrees.

Two participants reported working in “housekeeping” at a hotel. One of these two described himself as a supervisor. Three women in the study reported being homemakers as their principal occupation; however one of these women plans on finding a job when her infant ages a few more months. One participant works in a bodega<sup>4</sup>, stocking vegetables, and two more work in construction. One of the construction workers specified painting and bricklaying as his activities.

Respondents reported a range in length residence in greater Pittsburgh. One participant had only been in Pittsburgh eight days, two had been in the area for two months, one participant for a year, and one participant for four years. Three participants had lived previously elsewhere in the United States. One of these told me she had been in Pittsburgh for six months out of seven years in the States, one respondent had been in the city for one year out of one year and four months, and the other said he’d lived in Pittsburgh for three years out of five.

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<sup>4</sup> A small local grocer or corner store [47].

**Table 1. Demographic Information**

	<b>Mariela</b>	<b>María</b>	<b>Silvio</b>	<b>Raziél</b>	<b>Ana</b>	<b>Nene</b>	<b>Mauricio</b>	<b>Robert</b>
<b>Gender</b>	F	F	M	M	F	F	M	M
<b>Age*</b>	26-28	26-28	26-28	26-28	29-35	29-35	35-45	26-28
<b>Country</b>	Guatemala	Mexico	Mexico	Mexico	Argentina	Peru	Mexico	Mexico
<b>Residence</b>	Rural	Suburban	Urban	Suburban	Suburban	Urban	Rural	Urban
<b>Self-ID</b>	DK	DK	Mexican -Am	Hispanic	“Argentina”	“Peruana”	“Mexicano”	“Mexicano”
<b>Language</b>	Spanish	Spanish	Bilingual	Mostly Spanish	Spanish	Bilingual	Spanish	Mostly Spanish
<b>Living With</b>	Friend	Family	Parents	Alone	Family + mother	Family	Brother	Parents
<b>Education</b>	DK	DK	< High School	High School	High School	Grad. School	DK	1 Year Univ.
<b>Employment</b>	Hotel housekeeping	Homemaker	Construction	Hotel housekeeping	Homemaker	Homemaker	Construction	Stocking groceries
<b>Length of Stay</b>	Days	6 months	3 years	< 2 years	< 6 months	4 years	< 6 months	> 1 year

\*Respondents’ ages were collapsed into ranges to avoid potential identification of participants in this small, closely-knit community setting.

## **5.2 SATISFIED HEALTH CARE NEEDS**

Respondents were asked which health care needs they felt were currently satisfied. Satisfied and unsatisfied needs are displayed in Table 2. One woman expressed her satisfaction with her primary care provider, whom she had accessed through Medicaid while pregnant. One man mentioned his sister and mother's satisfaction with the "women's doctor" they accessed through The Midwife Center. I was not clear whether he was referring to a gynecologist, a midwife, or another health care practitioner. Another participant reported that members of his family received "less expensive" dental care at the University of Pittsburgh, and he planned on accessing this service soon as well.

Five patients mentioned their appreciation of the services offered by the Birmingham Clinic. One woman mentioned that she had accessed the clinic for a Pap test. Two patients expressed their satisfaction with the dermatological services offered at the clinic. One individual said he knew that he could use Birmingham for psychiatric services, and another individual cited chiropractic services. Neither of these patients had yet accessed the said services, but planned on doing so in the future. One participant mentioned that his access to health care has improved "Since I have met this Birmingham Clinic," referring to the range of services available.

### **5.3 UNSATISFIED HEALTH CARE NEEDS**

The most commonly reported health care need was dental services, mentioned by five participants. A need for health insurance was mentioned by four participants, although they cited different aspects of insurance, and supported their claims with different rationales. None of the participants reported having any kind of medical insurance. Two subjects reported needing optometric services, and two subjects mentioned wanting a “general check-up”. Two participants told me about their difficulty obtaining prescription drugs, specifically due to the differences between the American and Mexican systems of health care. One does not need a prescription to obtain most medicinal drugs in Mexico [48], whereas in the States one needs a doctor appointment before one can even gain access to the prescription needed to obtain these drugs. One mother expressed a desire for mental health services for her child. Another man reported having many “little” problems with his health. One man mentioned the need for health services that cater specifically to men.

One woman felt that medical service providers needed “cultural sensitivity training.” Another expressed her desire for “Hispano” or bilingual doctors and nurses, or at the very least available translators.

One patient reported difficulties with follow-up at the Birmingham Clinic. He had expected a phone call to schedule dermatological services, and this phone call never came. When he tried calling back the clinic, he got no answer, and gave up thereafter.

When asked if they believed they had additional health care needs that the Birmingham Clinic could not satisfy, four participants said they “didn’t know,” and three told me they were unsure because it was their first time visiting the clinic.

**Table 2. Health Care Needs**

	<b>Mariela</b>	<b>María</b>	<b>Silvio</b>	<b>Raziél</b>	<b>Ana</b>	<b>Nene</b>	<b>Mauricio</b>	<b>Robert</b>
<b>Satisfied health care needs</b>	Women's services (BC)	General needs (BC)	Dermatology, chiropractic [not yet accessed] (BC); Dental services (Univ. of Pitt)	General needs (BC); women's services [sisters] (Midwife Center)	Dermatology [mother] (BC)	PCP thru Medicaid while pregnant	Psychiatric [not yet accessed] (BC)	N/A
<b>Unsatisfied health care needs</b>	DK	Dental; health insurance and mental health services [children]; Hispano/bilingual providers or translators	General check-up	Dental; health insurance; optometric; pharmacological; men's health services	Dental; health insurance [children]; optometric	Dental; health insurance; cultural training for providers	Pharmacological	Dental; health insurance; general check-up

**BC = Birmingham Clinic**

#### **5.4 SATISFIED SOCIAL SERVICE NEEDS**

Satisfied and unsatisfied social service needs can be found in Table 3. One participant referred to his satisfaction with free English classes that he had completed through the University of Pittsburgh. One respondent mentioned accessing the Jewish Community Center's gymnasium to work out.

Two respondents mentioned the Greater Pittsburgh Literacy Council as a resource for improving their English skills. Two respondents mentioned their satisfaction with services obtained through the Centro Hispano. Four respondents mentioned that St. Hyacinth (San Jacinto) Church and its staff, specifically Sister Janice, had been instrumental in their receiving needed services.

#### **5.5 UNSATISFIED SOCIAL SERVICE NEEDS**

Two participants reported that they would like to access English classes. Another participant said that he would like to earn his General Education Degree, so that his educational level could be recognized in the United States. One subject said that he would like occupational training, specifically in operating machinery.

One participant described her desire for either bilingual services or translators when interacting with cable representatives, phone companies, and Food Stamps representatives.

Another woman expressed a need for “cultural sensitivity training” for employees of the bank, the post office, the Welfare office, and Medicare.

Two participants reported that they would like assistance obtaining a driver’s license. One participant told me that he had trouble obtaining a library card, because he did not have a driver’s license, and another woman said that not having a license prevented her from gaining employment. Three subjects also said that they needed better transportation options than those currently available with the bus and trolley system. Two participants mentioned difficulty buying cars, one citing his lack of car insurance as a barrier.

Two participants expressed a desire for a service to help them find a “better” apartment. One man said that he would like help finding a “better” job, one that paid more money and was a better match for his skill level.

One mother mentioned that she would like a free babysitting service for her children during normal business hours, because she would like to have a job. She agreed that it would be convenient to have such a service at her children’s school. She also mentioned a desire for free tutoring services for her children, in the area of English proficiency, as well as in general elementary school subjects. She could not help her daughter with her homework, due to her own lack of English proficiency.

One respondent told me he would like help paying for his gas bill. He had heard of a program where, based on income level, the city would alleviate partial responsibility for residents’ gas payments, but he did not know where to start looking for this program.

Another participant said that she missed the social opportunities of living in a big city, such as the theater, and restaurants that stay open twenty-four hours. One woman said that she

wished there was a community center, or some kind of “Centro Hispano” that she could use to access information and services.



**Table 3. Social Service Needs**

	<b>Mariela</b>	<b>María</b>	<b>Silvio</b>	<b>Raziél</b>	<b>Ana</b>	<b>Nene</b>	<b>Mauricio</b>	<b>Robert</b>
<b>Satisfied social service needs</b>	English classes	Church (SJ)	Hispanic services (CH); English classes (Univ. of Pitt); gymnasium (JCC)	English classes (GPLC); church	Church (SJ); Hispanic services (CH)	Church (SJ)	None	Church (SJ)
<b>Unsatisfied social service needs</b>	DK	Bilingual reps or translators for cable, phone, Food Stamps employees; public transportation; housing assistance; child care; tutoring [children]; a “Centro Hispano”	GED classes; purchase car; subsidized gas bills	English classes; occupational training; driver’s license; library card; housing assistance	DK	Cultural training for bank, post office, Welfare, Medicare employees; driver’s license; public transportation; social opportunities	English classes; car insurance; employment assistance	Public transportation

**CH = Centro Hispano**

**GPLC = Greater Pittsburgh Literacy Council**

**JCC = Jewish Community Center**

**SJ = San Jacinto Church**

## **5.6 CHANGES IN ACCESS TO SERVICES**

Results from sections 5.6 through 5.14 are found in Table 4. The presence of each variable is indicated by an “X,” and “DK” indicates that the participant answered that he or she “didn’t know.”

Participants were asked if their access to health care and social services had changed in the time they have lived here. Two respondents reported they had experienced positive changes. One said his increased access is directly related to the Birmingham Clinic, and another said that her improved access resulted from obtaining legal papers for her permanent residency.

One participant said that his needs have changed in the sense that because more of his family now lives here, they are in need of less expensive solutions to their problems. One respondent said that his access had not improved or changed in the time that he has lived here, and another said that he does not anticipate that his access will improve, based on his economic situation.

## **5.7 SENSE OF COMMUNITY**

One participant said that he felt he had a community here, in that if he needed something he knew enough people he could go to and ask for help. Another said that she liked living here, because of her proximity to her husband’s family. One participant’s mother, who was present at the interview, said that she found a sense of community in San Jacinto. One participant said that

even though she felt she “had no contacts,” she believed there were other Peruvians at San Jacinto Church.

Other respondents reported feeling that they were not part of a community. “Here,” one respondent told me, “you don’t run into Latinos,” like she had when she lived in Indianapolis. When asked if they felt they were part of a community, one said “without,” and another responded “there is not.” One of the participants told me that if he lived in Los Angeles or Miami, he would have an easier time, because “there are more Latin people.” One respondent’s husband commented that he felt out of place here, because people shake hands instead of kissing during a typical greeting or departure.

### **5.7.1 Social isolation**

Because community integration has a profound influence on access to health care [6, 41], especially within the Hispanic population [43], respondents were asked about their social experiences in the United States. Six out of eight respondents indicated feelings of extreme isolation. Mariela came here alone, and knows only one person. She said that even though she had been away from home for only eight days, she already missed her family. María felt that the lack of a Latino community in Pittsburgh made it much harder to navigate bureaucratic systems. Raziél also knew only one person when he arrived, although he has since found a church that he feels he belongs to. Even though Nene has her husband’s family to rely on for social support, she still misses many things about being in a community into which she felt more integrated.

Mauricio and Robert reported the highest degrees of social isolation; their situations have had a significant negative influence on their emotional conditions. Mauricio used the following

words (translated to English) to relay how difficult his experience has been, exemplifying his high degree of social isolation:

*Without English, I can do nothing. So far I have learned nothing of English. I live just down the street, and I've never been [to the fast food restaurant where we met]. I do not even know how to ask for a hamburger. For nothing. It's very sad. I miss Mexico, I miss my chickens, I miss my work. It's very difficult...but I don't want to leave, I am already here. Very difficult.*

Both Mauricio and Robert mentioned their limited ability to travel in and around Pittsburgh, which is directly related to their lack of transportation. They both told me that they have no friends here, and only very few family members. Neither of these men has been integrated into the San Jacinto community. They told me that their life consists of “leaving the house to work, and leaving work to go home”. They have “no friends” and “do not go out”.

## **5.8 SENSE OF PERMANENCE**

I asked participants whether or not they felt “permanent” here in Pittsburgh. One respondent will stay here for a few years, and then return to her home country. Another said that although he felt like Pittsburgh was his “home,” he will not stay forever. One respondent said he’d stay here with his family for at least another year, and then possibly go back to his country. One woman’s stay was dependent on the length of time it took for her husband to complete his PhD program, and then they would return to their home country as a family. One man said he felt that Pittsburgh is his “home,” and that he is now “more settled” than ever. One woman said she would like to stay in the United States, but possibly not Pittsburgh. Finally, one man described

that due to his economic situation, he “did not know” whether he would stay in Pittsburgh, another American city, or return to his country, even though he would prefer to stay here.

## **5.9 RACISM AND DISCRIMINATION**

Five participants agreed that they had experienced racism or discrimination while in Pittsburgh. One woman felt that the Food Stamps representatives treated her poorly based on her ethnic identity. Another woman told me that she had felt discriminated against in many different institutions, and that the employees of these institutions were “ignorant”. She felt that the way she looks and her accent cause people to treat her differently. For example, while she was going into labor, the doctor directed his questions about the level of pain she was experiencing to her husband. She was extremely frustrated by this, because not only is she highly proficient in English, but she thought it was “stupid” that the doctor would assume her husband could know what she was feeling. She also mentioned that in more informal and social interactions, people would also direct their questions to her Anglo American husband, even when the questions were about her.

Participants reported racist experiences in their personal interactions, as well as within institutions. One man expressed his desire to visit his home country to escape racism, and to be among “his people”. One man said that his mother experienced a problem on the bus system, and that she felt the driver ignored her request for a stop, based on her race. Another man said that when he enters a restaurant or store, he notices people quietly talking about him. One man had an overtly racist experience while on the road, when another driver yelled racial slurs out of his car window. One woman felt slighted by Americans’ general lack of knowledge about other

cultures. She was frustrated that people assumed she was Mexican, and when they learned she was from Peru, she felt that Americans still reduced her to some kind of informational resource about Mexico. One person told me he felt that African Americans in his neighborhood treated him as if he was a racist.

One respondent wanted to make sure I knew he had not experienced racism at the Birmingham Clinic. Another respondent told me he had never experienced discrimination from any health care provider. Two participants said that they had never experienced racism of any kind here in the States, and the husband of one of these participants told me he felt that this was because they looked white, and did not have the facial features typical of indigenous persons.

Nene provided examples of cultural incompetence while navigating bureaucratic systems. One time in the Post Office, a worker assisting with forms wanted to know her first language. Nene was surprised to learn that this employee of the U.S. government did not know that Spanish is the primary language spoken in Peru, and was offended when the worker asked her if she spoke “Peruage”. She also told me about an experience she has encountered both in institutions and socially:

*People always think that I am Mexican. When I tell them that I am not, and that I am from Peru, they still keep asking me questions about Mexico, like I should know and like I am still from there. I am like, I don't know, I have never been there! Do you know where Peru is? South America is much further from Mexico than the United States!*

## 5.10 FEAR

Study participants indicated that “fear” prevented them from accessing services, and others also indicated that feeling fearful affected their daily life. This fear is due to their status as immigrants. Sometimes this is related to a lack of complete documentation. For example, one may have immigrated legally, yet his or her documentation has since expired. For some, fear may be due to illegal immigration. Persons with complete and legal documentation still experience fear, because of the feeling that the government has control, including the ability to deport any person at any time for any reason, founded or unfounded.

Two respondents did not explicitly say that feelings of fear restricted their own access, but that they “know some people” for whom it does. They felt that the fear resulting from illegal immigration status was a barrier that kept Latin Americans from obtaining needed medical care. One woman said that although she was a permanent legal resident, fear will be a part of her life until she is a full-fledged citizen of the United States. Another man said that he felt he had to live his life, “without errors,” and that he had to “speak very carefully.” When I asked Robert how fear affected his daily life, he replied in a manner which underlined how fear may be related to increased social isolation (translated to English):

*Going out to have fun, doing something. I don't know the restrictions that exist. For example, [Cinco de Mayo] was the third or fourth party I have been to. This is because I am always with my family, and I never go out with friends. I don't have friends here. Or anyone else I can go out with. My life is going to work, and going from work to home. I have the computer, and drawing, and that is all.*

## 5.11 MOTIVATION FOR IMMIGRATION

The reasons cited by study participants for immigrating to the United States offer insight into the degree of access to services they experience. Most of the people I interviewed chose Pittsburgh because they already knew someone here: a friend, a brother, a parent, or a spouse. However the range of access experienced by these immigrants is dependent on social factors, as well as individual perceptions.

Those who reported immigrating to the United States for economic reasons had the most limited access to health care and social services. Four participants came to Pittsburgh exclusively to make more money than they had been making in their home country. Mariela immigrated here to send remittances back to her family in Guatemala. She is the eldest of seven siblings, and her father is no longer alive, so it is her responsibility to help take care of the family. María immigrated to Indiana to work when she was only twenty years old. I met María in her home, which did not have sufficient furniture, nor was it very clean. Raziél came to the United States to escape religious discrimination; he is not Catholic and said that for this reason, he cannot find a job in Mexico. Mauricio also came here to find work, in hopes of earning more money than he could back home.

These immigrants do not find immediate economic relief. Mauricio told me that he is making the same amount of money here as he was at home, but that the level of income is worth less here, relatively speaking. If he does not find a better job, which is more appropriate for his skill level, he will return home to Mexico. He is a qualified mechanic; however, without certification, he cannot be legally employed to fix cars in the United States. He is also experienced in raising chickens, and he has not yet been able to find work on a farm. Since



working in Pittsburgh, he has recently had to learn how to paint houses, which he finds frustrating since he is qualified to do other jobs that would most likely pay more.

On the other hand, those who immigrate for reasons not related to their economic situation may have an easier time navigating this new system of services. Nene came here to marry a man she met online. She was already college educated, and was able to enroll in a Master degree program soon after she arrived. Her home, which was in a working-class suburb, was very well kept and undergoing construction purely for aesthetic improvement. Ana accompanied her husband, who is working on his fully funded Doctoral degree in “freelance consulting informational technology”. They lived in a spotless apartment, with beautiful crystal and home décor that do not come inexpensively. Ana’s mother had lived here for seven years previously, and that is why Ana’s husband chose Pittsburgh in lieu of another city. Robert immigrated to accompany his mother and brother across the border, to live with his father who had already been here for years with steady employment. These persons arrived here to find an existing and stable economic environment. This same group of people also expressed less frustration when trying to locate where to access needed services.

## **5.12 INSUFFICIENT DOCUMENTATION**

Nene said that before she had her paperwork in hand, she had “no access” to medical care, even though she immigrated legally. She told me stories about how long it took to navigate the bureaucratic system, and the many setbacks she experienced when trying to adhere to the United States’ immigration policies. It was also an expensive process, which she was fortunate enough to be able to afford.

Raziél and María both immigrated legally, but since then their papers have expired. Raziél expects to have his social security card within months, and after this he hopes to buy into his employer's medical insurance policy. María said that although she is not currently legal, her children are American citizens. However, because her immigration paperwork was not current, the Food Stamps representatives wanted to refuse her entire family service, including her legal children. She mentioned that this was not a problem for her in Indianapolis, and she believes that this is because there are more Latinos there. This also may be, she mentioned, why Food Stamp employees in Indianapolis did not discriminate against her the same way that Pittsburgh's did, because they are more accustomed to dealing with issues of incomplete documentation.

Robert and Mauricio both mentioned their desire to purchase cars, yet without documentation, they cannot obtain licenses, nor insurance policies.

### **5.13 INDIVIDUAL PERCEPTIONS**

Some participants alluded to the fact that they did not require health care services because they did not feel they needed them. Mariela did not anticipate having any health care needs because she said she is "not worried" about her health. Raziél said that he had never attended a clinic before because he "wasn't sick". Ana joked with me that while she wanted medical care services for her children, she personally "won't need them," hinting at the fact that she hopes she will not need them in the future. Ana's mother did not see a doctor for the first five years she lived in the States, because she "never needed them". Nene said she did not try to find a service provider during her documentation transitional phase, because she "always had good health".

## 5.14 ADDITIONAL OBSTACLES

Several other obstacles mentioned by participants do not fit directly into the previously noted categories. María's cousins were in jail, which negatively influenced her perception of her Pittsburgh experience. Mariela and Robert both mentioned the trying experience they endured while crossing the border into the United States. Mauricio resented his economic status, because he felt it had not yet improved, and probably would not in the future. As a skilled worker, he expressed his frustration in our conversation:

*Here I do not have the work I want, and I can't change my situation...here I have to learn everything. They teach you how to work. They teach you how to speak English. Many things. Learning many things here makes it difficult to be in the United States.*

Ana told me about how it is the “little things” that made her time here difficult, for example, the new climate and the new cleaning products she was using had taken a toll on the condition of her skin.

**Table 4. Additional Information**

	<b>Mariela</b>	<b>María</b>	<b>Silvio</b>	<b>Raziél</b>	<b>Ana</b>	<b>Nene</b>	<b>Mauricio</b>	<b>Robert</b>
<b>(+) changes in access</b>			X			X		
<b>(-) changes in access</b>				X			X	X
<b>(+) sense of community</b>			X		X	X		
<b>(-) sense of community</b>		X	X	X	X	X		
<b>Social isolation</b>	X	X		X		X	X	X
<b>Permanent situation</b>		DK		X			DK	DK
<b>Experienced racism</b>		X	X	X		X		X
<b>Experienced fear</b>		X				X	X	X
<b>Immigrated for \$ reasons</b>	X	X		X			X	
<b>Immigrated for family</b>			X		X	X		X
<b>Documentation access barrier</b>		X		X		X	X	X
<b>“Not sick” access barrier</b>	X			X	X	X		

## **5.15 COMMUNITY EDUCATIONAL SESSIONS**

Information about the community educational sessions can be found in Table 5. Six participants were asked whether they would be interested in attending community educational sessions in Spanish, about topics related to health and medical care. All six said they would be interested in attending.

I asked participants about which topics they would like to learn more. Two participants, who initially misunderstood my aim of this question, responded “English”. One man said that he would like to learn about “all” topics. One respondent said that he would like to learn about respiratory diseases, about preventative health care, and about which vaccines a person should have. Others focused on topics more related to social service needs than health care needs. One man said he would like to attend a class to learn more about credit, for example how to check his credit score, and how to improve his line of credit. He also wanted to know more about how to get a driver’s license, and how to access public libraries.

Participants identified a range of appropriate meeting locations and times for these sessions. One man suggested a local high school or church. Another participant thought that the Birmingham Clinic would be a good venue. Three respondents agreed that San Jacinto would be an ideal place to meet.

Two respondents told me that the meetings would be most convenient if held on Sundays. One respondent cited that evenings in general are best, and another cited afternoons. One person told me that his availability changes. Another respondent said “any time” would be fine.

I also wanted to know what presenters could do to help increase attendance. One man told me that all I had to do was “catch people’s interest”. Two others cited their personal barriers to attendance: one said that work is a problem, because sometimes he has to endure long drives, and the other said that having free time is a problem, because he has to work, go to the bank, and buy food.

**Table 5. Community Educational Sessions**

	<b>Mariela</b>	<b>Silvio</b>	<b>Raziél</b>	<b>Nene</b>	<b>Mauricio</b>	<b>Robert</b>
<b>Would attend</b>	X	X	X	X	X	X
<b>Which topics?</b>	English	DK	English; credit building information; accessing library	DK	All topics	Respiratory diseases; vaccines; disease prevention
<b>Meeting location?</b>	DK	Birmingham Clinic; San Jacinto	Local high school; local church	San Jacinto	DK	San Jacinto
<b>Time?</b>	DK	Evenings	Depends, it changes	Anytime	Sundays; afternoons when work is done	Sundays
<b>Attendance concerns</b>	DK	Distance is an obstacle.	Being very busy is an obstacle.	DK	Increase numbers by catching interest of the people	DK

## **6.0 DISCUSSION**

The Latino immigrants I interviewed demonstrated that English proficiency has a profound impact on access to services, which is consistent with previous research [2, 28, 34]. The existence, scope, and size of social networks also tend to affect access, as found in the literature [2, 41, 42, 43]. This is directly related to the level of community integration these people experienced. Legal documentation and the fear associated with it are the most important determinants of whether or not a Hispanic immigrant has access to social and medical services, as suggested in the literature [26]. This study is the first to provide a window into the lives and range of obstacles experienced by Pittsburgh's immigrant Latinos. I have provided local health care providers and interested parties such as the Birmingham Clinic, San Jacinto Church, and the Centro Hispano with a one-page bilingual synopsis of my findings and applications (see Appendix B).

### **6.1 SOCIAL STABILITY**

There is disagreement about whether or not Pittsburgh Latinos are experiencing greater stability, as indicated in previous examinations [3]. Based on the sample in this study, it is not clear whether this population is experiencing greater stability. However, the level of community

integration, a component of social stability, does seem to have an impact on access to health care and social services.

One of the variables used by researchers to assess community integration is church attendance [42], and in the case of these immigrants, involvement with the church of San Jacinto does improve access to services. Another variable cited as having an impact on access to services is the size of one's support network [25], and those respondents with more members of their family in Pittsburgh experienced better emotional health [6] and better access to social and medical services [42]. Without social contacts, not only do persons have limited knowledge of and access to the health care system [43], but they have a greater risk of suffering from mental health problems, such as depression [40].

As discussed earlier, although English proficiency does not necessarily equal cultural integration [36], in this study participants with strong English skills were able to seek and receive care from a wider variety of service providers [8, 28]. This study reinforces the finding that English skills significantly improve access to medical care, because English proficiency improves one's ability to navigate complex bureaucratic systems [8]. Thus, English as a Second Language classes would benefit the community socially, and increase their available access to health care. Alternatively, special attention should be paid to ensure that interpreters are available for Spanish-speakers, and in fact for all non-English speaking patients [12]. In addition to linguistic compatibility, knowledge of the host country's culture also significantly improves access to services [8].

Respondents indicated that increased length of time residing in Pittsburgh has not directly enabled them to get help with a wider variety of health care needs. This runs contrary to what some researchers suggest [49]. For the most part, participants gained access to services through



their social networks, and many of these social networks [2, 25, 41, 42, 43], involving kinship and community of origin, are the same ones that existed prior to arrival in the United States.

Nene and Silvio were the only two participants who indicated that increased time spent in the United States was related to their increased ability to navigate the health care system, and they agreed that this increased ability was not directly linked to their length of stay. Silvio indicated that, although his access has improved over the four years he has lived in Pittsburgh, he felt this improvement was related exclusively to his discovering the Birmingham Clinic. Nene indicated that her improved access over time was a result of her receiving the documentation necessary to obtain a Green Card. While both participants had specific reasons that explained their increased access, it is interesting to note that Nene and Silvio were the two participants who demonstrated the highest levels of English proficiency in the sample.

## **6.2     LEGAL STATUS**

It is clear from this study that health insurance coverage would improve the quality of life for each person interviewed. Currently, this is not an option, even for most documented immigrants [50]. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 placed a five-year ban on Medicaid availability for immigrants. A similar law passed in 1997 applies similar restrictions to the children of immigrants. In 2005, the Deficit Reduction Act mandated proof of citizenship when applying for Medicaid. Not only would immigrant health care recipients benefit directly from an extended “guest worker policy,” but providing immigrants with regular preventative care would cost institutions and taxpayers less than the current policies [51]. Legal documentation is a controversial topic. However, it is clear that undocumented

immigrants do contribute to Pittsburgh's economy, even though politicians and service care providers cannot agree on this. Because it is more cost-effective to provide primary and preventative care, as opposed to emergency care [51] (which providers are ethically obligated to do), it makes financial sense to provide such preventative health services to everyone. This will require changes at the policy level, which are currently politically difficult to achieve.

It appears from this study that legal status is the strongest determinant of immigrants' access to health care and social services. This finding is consistent with findings in the literature [26]. When a person does not have appropriate paperwork documenting immigrant status, fear of deportation and other legal consequences often prevent that person from obtaining needed services. This was verified by participants in the current study, as María, Raziél, and Mauricio all indicated. Even with documentation, immigrants often face limited access to needed health care services. Nene shared that, even when she was documented as legal, her actual status did not affect her access to services until she had the papers in hand, which often takes months or years, as it did in her case.

Many participants said either they lived in fear, or they "knew someone" who does not access services due to fear. Both participants with complete documentation and those who were undocumented mentioned this as a health care and social service barrier. This is consistent with much of the literature, which notes that fear often prevents immigrants from accessing needed care [52].

### **6.3 “SICK” CARE**

There is evidence that many Latinos do not visit a doctor until they actually have a physical ailment or disease [53, 54]. This has already been documented within greater Pittsburgh’s Latino population [2]. Participants in the current study also mentioned that they only seek health care services when they are sick. A number of factors contribute to this. The Pittsburgh Latino population’s need to earn money for themselves and their families often requires them to work until they get really sick [2]. Also, many of the participants in this study placed a premium on seeing themselves as healthy, and not worrying about health issues. The self-image of “healthy” reduces one’s sense of urgency in regard to finding a reliable and consistent health service provider. However, having these perceptions could be risky. For example, in the event of a medical emergency, it is always better to have a standing relationship with a primary care provider, or at the very least to have some kind of medical records on file at a clinic such as Birmingham. In addition, individuals who do not feel the need to be concerned about their health are missing out on preventative care services. Not only are they less likely to receive health screenings and vaccinations, they also do not receive important medical information that may have a significant positive influence on their health.

Because uninsured persons in general, and Latinos in particular, may be less likely to seek health care and more likely to visit hospital emergency rooms when they do seek care, hospital emergency rooms should be seen as access points to the Latino population, and they should provide referrals to other more regular providers of care who typically offer preventative as well as emergency treatment [12]. In addition, having urgent care or preventative clinics more available to the Latino population, in terms of both geographic location and hours open to the public, might reduce reliance on emergency room visits.

## 6.4 CULTURAL COMPETENCE

Participants in this study noted that language incompatibility (lack of Spanish proficiency by most health care providers, and lack of English proficiency on their own part) is a major barrier to quality health care services. Because Hispanic persons are not proportionally represented in the health professions [8, 21], a special effort should be made to recruit, train, and employ Hispanic providers of health care, especially in neighborhoods and communities where there are concentrations of Hispanic residents. If we are to correct the absence of minority health care professionals in our society and compensate for their long-standing exclusion from health care fields, some form of affirmative action is absolutely necessary and long overdue. Until minority representation in medicine, public health, and other fields of health care reflects the proportion of minorities in the population, their underrepresentation will continue to pose a barrier to health care access and utilization by members of those populations [8]. Increasing the number of Latinos in the health care fields will ensure that the health care system can respond to the needs of the population in a manner that is culturally appropriate. This includes areas like greater Pittsburgh, where the Latino population is small but steadily growing, and where lack of Hispanic health care providers is notable.

Part of the education of health care providers about the cultural and social mores of Latinos should include training on issues such as the heterogeneity within the Latino population. It is important for health care providers to recognize that the population of Hispanics includes people from countries as different from each other as Mexico is from Argentina or from Brazil. Most people labeled Latino speak Spanish, while others speak Portuguese. Others are most comfortable with an indigenous language or local dialect, and some Hispanic people are as comfortable with English as most Anglos. The substantial variations among Latinos in ethnicity,

country of origin, language of choice, and length of residence in the United States all influence differences in access to and comfort with the health care system [21, 27].

Factors to consider when looking at ethnic variation among Hispanics include the specifics of how Hispanic peoples from different countries should be seen in relation to the U.S. health care system. For example, it is important to know that there are more Mexican Americans in the United States than any other Latino group, and this concentration may skew data about how Mexican Americans relate to the health care system in comparison to other Hispanic ethnic groups [21]. It is also important to know that Puerto Ricans have better access to health care than most other Latinos, with a pattern similar to that of African Americans. This is due to Puerto Rico's status as a protectorate of the United States, which grants island residents American citizenship and increases their access to American institutions. Because of this history, most Puerto Ricans are familiar with the cultural orientation of the U.S. health care system [21].

## **6.5 THE NEW GROWTH EXPERIENCE**

When assessing health care access of immigrants in Pittsburgh, it is important to take into account this location's unique situation. As previously mentioned, the Latino population of southwestern Pennsylvania is a new growth community, as opposed to a historically major Hispanic center, like New York, Miami, or Los Angeles. According to the Kaiser Foundation, the Hispanic population in new growth areas nearly doubled between 1996 and 2003 [44], which is a rate comparable to that of Pittsburgh [1]. In major Hispanic centers, up to 50% of the population may be of Hispanic origin, whereas in new growth communities the population

proportion is usually under 5% [44]. In Pittsburgh, the Latino population is estimated to comprise about 1% (P. Documét, personal communication, April 24, 2007).

In large metropolitan areas with a high proportion of Hispanic residents, there exist complex and well-developed service centers which cater specifically to Spanish-speaking and immigrant communities. Hospitals and social service providers have developed specific strategies to reach Latino families with limited incomes, and the institutions also make an effort to hire bilingual, often Hispanic, and culturally competent staff members. As a new growth area, health care providers in Pittsburgh have less experience serving Latinos, and may not be sufficiently equipped to meet their needs [44]. For recent immigrants, the situation is even more complex because not only are they less likely to have health insurance, but more likely to face linguistic and cultural barriers. Recent immigrants are also more likely to encounter racist, anti-immigration attitudes.

The fact that Pittsburgh is a new growth Latino community means that little research has been conducted within the Latino population, as opposed to major Hispanic centers, where research is available documenting the last few decades of immigration. The paucity of data about Hispanic residents and access to health care in Pittsburgh adds significance to the current study, and also strengthens the argument that more research is needed.

While there are limited data on Pittsburgh's "new" immigrant population, a brief review of recent newspaper publications offers a window into this particular situation. Historically, Pittsburgh was settled by European immigrants. In the 19<sup>th</sup> and early 20<sup>th</sup> centuries, the city was comprised of many ethnic communities, namely Irish, French, British, Italian, Polish, and Eastern European immigrants. An article from 2005 points to the fact that the United States' immigration restrictions in the 1920s and 30s slowed the influx of immigrants to a near-halt [55].

Since this point, the distinct ethnic neighborhoods have intermarried, and formed what is now considered the United States' melting pot of "American" culture. This means that "Pittsburghers" have not had to face new immigrants for nearly a century.

One recent article cites that Pittsburgh has lost more residents since 2000 than any other American city, except New Orleans, where the population loss is attributed to Hurricane Katrina [56]. Because Pittsburgh does have a relatively low international immigration rate, annual mortality rates are higher than birth rates, and young professionals are migrating out of the city, population numbers are still on a decline. Another article from 2007 describes that many of the Anglo residents, who are the descendants of European immigrants, demonstrate an "anti-immigrant" and racist sentiment [57]. The article also points to a perception among Pittsburgh residents that "all" Hispanic immigrants are illegal, and unwelcome. Both of these articles suggest that immigrants in Pittsburgh should be viewed as a solution, and not a problem. Without a significant increase in Pittsburgh's labor force, the economy will also continue to decline.

While still relatively small in number, Latin American immigrants are coming to Pittsburgh, and do require health care and social services. Resistance to providing quality services will only make the situation more difficult. One article states that the majority of international immigrants to Pittsburgh are usually highly skilled professionals from the continent of Asia, unlike the blue-collar immigrant populations in major Hispanic centers [58]. In reality, it is in the health care institution's best interest to provide culturally appropriate services to all of Pittsburgh's ethnic groups, including the most recent. While incorporating successful strategies from major Hispanic centers will assist providers in developing programs to serve Latinos and

other immigrants, the situation in Pittsburgh is unique, and thus health care systems here will require an innovative and unique design.

## **6.6 LIMITATIONS**

While the findings from this small sample are not generalizable to the Latino or immigrant community as a whole, participants did provide a wealth of information which enabled me to develop many important insights. To build on the results of this study, enough interviews would need to be conducted in order to reach the saturation point necessary to draw population-wide conclusions, or to represent all perspectives. Furthermore, the multiplicity of social factors that affect one's access to medical and social services make it even more difficult to generalize. Not only is the Hispanic population itself heterogeneous, but there are many factors that affect access to care. These include, but are not limited to: socioeconomic status, immigration status, phenotypic appearance, age, educational level, length of stay, as well as individual personality traits and prior experience with American health care and social service systems. It should be noted that all of the participants in this study lacked medical insurance, and it is possible that immigrants who do have insurance are more integrated into the mainstream health care system, and do not receive care at free clinics like Birmingham.



## 6.7 RECOMMENDATIONS

Continuous, increased funding for the Birmingham Clinic is likely to have a positive impact on the health status and general well-being of Latin American immigrants in Pittsburgh. In addition, other free or sliding-scale clinics should consider incorporating bilingual services as does the Birmingham Clinic. For example, the Squirrel Hill Health Center in Pittsburgh now offers services in Spanish, as well as American Sign Language, Russian, and Hebrew. Nevertheless, the Birmingham Clinic is still the only clinic in Pittsburgh to offer *free* bilingual services to immigrants.

Latin American immigrants in Pittsburgh would benefit from increased community outreach. Many respondents indicated that they did not know the full range of services offered by the Birmingham Clinic. In addition, some participants did not know about the Centro Hispano or San Jacinto Church. These are pillars of support for Pittsburgh's Latino community, and these institutions should develop new and aggressive strategies to increase knowledge about their services among community members. Social opportunities, such as parties, gatherings, or informational sessions sponsored by these institutions will help increase awareness. San Jacinto currently holds some events like this, such as an annual Latino information fair.

In addition, general, broad-based community organization should increase awareness of available services, and thereby increase utilization of these services. Internal mobilization strategies should be employed by organizations like San Jacinto and the Centro Hispano. Researchers on community empowerment agree that involving community members themselves in a collaborative process is the best way to ensure that mobilization strategies will be culturally competent and effective [59]. This community has no doubt begun their self-organization, and with the help of neighboring institutions, like the University of Pittsburgh, this process can

continue successfully. Partnering with institutions such as the university allows both parties to benefit: the university benefits through increased opportunities for research, while the population benefits from the knowledge previously generated at the university [59]. While the population members themselves are the experts on their community's needs and strengths, the university may be able to offer previously verified and successful mobilization strategies to apply within the community context.

Finally, more research is needed. Because of the limited number of participants in this study, it should be viewed as a pilot study. More qualitative data from community members will provide a foundation for more insights into the complex social factors that both open and limit access to health care and social services for greater Pittsburgh's Latino population.

## **APPENDIX A**

### **RECRUITMENT FLYER**

¿Cómo es su experiencia con salud, y servicios sociales aquí en Pittsburgh?

- Quiero saber más de cómo es la vida del inmigrante Latino Americano, especialmente al respecto cuidado médico.
- Estoy buscando a voluntarios para tener una conversación personal conmigo, de estas cosas importantes.
- Su entrevista será representada en la tesis de mi Masters de Salud Publica.
- No va a recibir compensación, pero sus respuestas ayudan a la comunidad Latina de Pittsburgh.

Si piensa que Ud. puede ayudarme, por favor, llameme or escribame en:

Mara DeLuca, (412) 337-2337, o mdlcat@yahoo.com

## APPENDIX B

### HEALTH CARE AND SOCIAL INTEGRATION AMONG PITTSBURGH'S UNINSURED LATINOS

#### Thesis Research Findings

There are over 20,000 Latinos and Hispanic people in the Pittsburgh area. Because Latinos in Pittsburgh do not live in just one area, they may have a harder time getting the health care and social services they need. I interviewed eight young adult Latin American immigrants, who do not have medical insurance, to ask about their needs, and how their access to care has changed during the time they have lived in Pittsburgh. Here are my findings:

- **NEEDS:** Many people mentioned needing a **dentist, health insurance, bilingual doctors and nurses or translators, and English classes.** A few mentioned optometrists and help getting a driver's license.
- **PROBLEMS:** Living life without many **family or friends** is a problem for immigrants. **Racism** and **people who do not understand Latino culture** were mentioned by many. Also, lack of **legal documentation** and the **fear** related to this can keep someone from getting the help they need. The amount of time someone lives in Pittsburgh does not seem to improve their access to services. Rather, the size of their social network when they arrive is related to access, and over time, immigrants without family here do build social networks which increase their access to care.
- **ASSETS:** The people I interviewed told me how the **Birmingham Clinic, St. Hyacinth (San Jacinto) Church,** and the **Centro Hispano** helped them the most. Some also mentioned the Midwife Center and the Greater Pittsburgh Literacy Council.

**What's next?** Based on my findings, I recommend several things. More outreach on behalf of community centers will help this population improve their status. The Latino Catholic community has in the past, and should continue to mobilize community members. Also, a larger-scale research study based on this study's findings will help inform the public of Latino issues, and make sure that the help they receive is a good fit for Latin American culture.

My abstract and full thesis will be available online as of August 2007. For more information on this study and its findings, feel free to contact me.

By: Mara DeLuca, MPH

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## **NECESIDADES MÉDICALES Y INTEGRACIÓN SOCIAL ENTRE LATINOS SIN SEGURO DE MÉDICO EN PITTSBURGH**

### **Resultados de la Investigación de la Tesis**

Hay más de 20,000 latinos en el área de Pittsburgh. Como los latinos en Pittsburgh no viven sólo un área, puede ser difícil para ellos conseguir cuidado médico y servicios sociales necesarios. Entrevisté ocho adultos jóvenes que son inmigrantes de América Latina, y que no tienen seguro de médico. Les pregunté acerca de sus necesidades, y de cómo su acceso a los servicios ha cambiado en el tiempo que han vivido en Pittsburgh. Estos son mis resultados:

- **NECESIDADES:** Muchas personas mencionaron que necesitan un **dentista, seguro médico, doctores y enfermeras bilingües o traductores, y clases de inglés**. Algunos mencionaron optometristas y ayuda para conseguir la licencia de conducir.
- **PROBLEMAS:** Vivir la vida sin **familia o amigos** es un problema para los inmigrantes. El **racismo** y la **gente que no comprende la cultura Latina** fueron mencionados por muchos. También la carencia de **documentación legal** y el **miedo** asociado con eso puede impedir que uno reciba la ayuda que necesita. Vivir más tiempo en Pittsburgh no parece mejorar el acceso a los servicios. En realidad, el número de personas que uno tiene cuando llega a Pittsburgh está relacionado al acceso. Con el tiempo, los inmigrantes sin familia aquí construyen redes sociales que mejoran su acceso al cuidado.
- **VENTAJAS:** Los que entrevisté dijeron que la **Clínica Birmingham**, la **Iglesia San Jacinto**, y el **Centro Hispano** les ayudaban mucho. Unos mencionaron el Midwife Center y el Greater Pittsburgh Literacy Council.

**¿Qué hay que hacer?** De acuerdo con mis resultados, recomiendo varias cosas. Primero, que los centros comunitarios traten de llegar más a la población (“outreach”) puede ayudar a mejorar su situación. La Comunidad Católica Latina en el pasado ha contribuido a movilizar a los miembros de la comunidad y lo debe seguir haciendo. También, sería bueno hacer un proyecto de la investigación más grande basado en estos resultados, para informar al público de sobre las necesidades de los latinos y asegurar que la ayuda que se da sea apropiada para la cultura Latinamericana.

Mi resumen y la tesis completa estará disponible en internet, agosto 2007. Para más información de la investigación y los resultados, por favor, escíbame por email.

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